STATE HOSPITALS

I. STATEMENT OF ISSUE:

What policy should the state pursue in relation to state hospitals and community-based programs?

1. Continue present operations with no significant changes.
2. Increase funding for SH programs, including establishing satellite programs.
3. Increase funding in community alternatives for current (MR, MI) state hospital patients resulting in closure of some state hospitals.

BACKGROUND:

The first state hospital in Minnesota was opened at St. Peter in 1866. One hundred years later, Minnesota had 10 state hospitals serving over 15,000 patients. The basic philosophy of these hospitals was to isolate certain individuals from society.

In the 1950's & 60's a new group of social reformers successfully argued for normalization: that disabled people should live where they have the best opportunity to lead normal lives. The reformers further argued that community settings, rather than state hospitals, would provide the least restrictive environment for most people. This led to deinstitutionalization, abroad reform, with two main thrusts: 1) creating a full range of new community services, and 2) reducing the population of state institutions.

Federal and state governments passed laws to encourage the development of community services, and to reduce state hospital populations.

As a result, in 1980, the population in state hospitals was 4,849 and in 1986, it was 3,589. Two state hospitals, Rochester and Hastings, had been closed.

Between 1960 and 1980, significant changes also occurred in the population of various disability groups throughout the system. Mental illness programs were historically larger than the others. However, by the late I960's, the number of mentally ill patients had fallen below the number of mentally retarded residents. During the 1960's and 70's, the number of patients treated for chemical dependency increased steadily.

The Department of Human Services responded by establishing a "regional" system of mental retardation programs. As new space became available due to reductions in the mentally ill population, mental retardation programs were added at hospitals which had previously served only mentally ill or chemically dependent patients. Some argue that this evolution has been beneficial in allowing the hospitals to provide a full range of services to all disability groups in different regions of the state. Others contend, however, that the actions designed primarily to save hospitals whose mental illness programs and populations were steadily shrinking.

Meanwhile, in the early 1970's, advocates of handicapped persons followed the lead of the civil rights movement and turned to federal courts to achieve their goals. In Minnesota, state hospital residents and their families turned to the courts partly because of staff reductions at state hospitals, A group of parents of state hospital residents brought a suit in federal district

court in 1972 against the Department of Human Services and all eight state hospitals which then served mentally retarded persons. The suit is commonly known as the Welsch case, after the first named plaintiffs: Patricia Welsch, a resident of the state hospital at Cambridge, and her parents. In 1977, a consent decree between the parties focused on institutional reform; that is, improving the conditions and treatment at state institutions.

In the second phase of the litigation, beginning when the case returned to court in 1980, a second focus emerged: reducing the population of state hospitals and fostering community services. After the plaintiffs had presented their case, the parties negotiated a new consent decree, which became effective on September 15, 1980, and is to run through June 30, 1987. The new decree extended the institutional reforms to all state hospitals serving mentally retarded persons. It also included a state commitment to reduce the population of state hospitals by nearly one-third and to develop appropriate community services to serve state hospital residents.

Advocates for the mentally ill are currently threatening similar legal proceedings to obtain what they consider adequate staffing and treatment capabilities for state hospitals MI patients.

The Welsch case is only one of several forces which have changed state hospitals in the past 20 years. Three other developments have been equally significant. They are:

- the participation of state hospitals in the Medical Assistance Program; ($140 million in receipts per year for approximately 4 years.)
- the use of Medical Assistance funds to develop community group homes; and
- the 1985 federal waiver for MR community services; and
- the establishment of special education programs for mentally retarded children in local school districts.

CURRENT SYSTEM

At present, Minnesota operates eight state hospitals for persons with mental illness, mental retardation, and chemical dependency. Minnesota is one of the few states whose state institutions serve more than one disability group on individual campuses. In 1986, mentally ill patients made up about 35 percent of the state hospital population, mentally retarded residents were about 50 percent of the total, and chemically dependent patients were about 15 percent of the total.

The total budget for state hospitals in 1986 was about $168 million. About $140 million of this was paid for by the Medical Assistance program.

In 1986, the Minnesota Legislature passed legislation directing the states chemically dependency treatment programs to be funded from what has been termed the Consolidated Chemical Dependency Fund.

This legislation places the state hospital CD programs in competition with private CD programs. The state hospital programs, after a short period of adjustment, must be able to operate from their receipts. It is difficult at this time to determine what impact this fund will have on stale hospital populations.

Therefore, for the purposes of this issue paper we will not deal with the state hospital (or community) CD programs. Estimated costs of these CD programs will be deleted from state hospital (est. Hit) budgets.

We will be dealing here with only the MR and MI programs. The population projections for the MR and MI categories of state hospital patients are somewhat clearer, although by no means absolute.

- MR populations will continue to drop. Some suggest no MRs in state hospitals by the mid 1990's.
- MI populations could remain somewhat stable but can be definitely influenced by additional community facilities.

Summary

As a consequence of the above background developments, we now have 2 systems delivering treatment services to MI and MR clients. We have the state hospital delivery system and the community delivery system.

Discussion

The state hospital delivery system is a shrinking system while the community delivery system is expanding. State hospital patient populations have declined substantially but reductions in state hospital staffing has not kept pace.

This results in increasingly high per diems and average annual costs per bed exceeding $60,000.

It also results in duplicating some services and costs in both delivery systems. For example, it is commonly held that the less severe MI and MR patients are treated in the community setting and the more severe are treated in the state hospital setting. However, there are still a number of MI and MR patients in state hospitals who are not diagnosed as severe.

Clearly the state has been trying to support both delivery systems. Why has the state been so reluctant to reduce its investment and support in the state hospital system in the face of its declining usage?

The State Planning Agency study of state hospitals in 1985 identifies the basic reasons for this policy.

- Economic impact of state hospitals on local economies.
- State employee unions want to protect their members state hospital jobs.
- State has big capital investment in bricks and mortar which it is reluctant to abandon.

As a result of the above factors the states apparent prevailing policy, whether intentional or not, seems to be to maintain the state hospital system at some reasonable operating level. In the meantime, search for "alternative" uses. So far no viable alternative uses have been identified. Closure of one or more state hospitals appears to remain a very unpopular last option.

Meanwhile, the community delivery system is pressing the state for more of the resources it feels it needs to meet its growing responsibilities i.e., the $26

million for new MH initiative grants and 15 new administrative staff to administer and support these new community based programs. Just by coincidence, the $26 million requested for the MLH new initiatives grants is about what it costs to operate a state hospital for a year.

The following tables show the respective estimates of costs and clientle served in both the state hospitals and in the community in F.Y. 1987.

Statistics

Estimated F.Y. 87 Costs by System

Est. No. Served	Delivery System	Est. 87 Expenditures By Millions	Est. 87 per Diem Cost
3200	Chronic MI Grants (14)	$ 3,684	$ 3.15
1800	Rule 12/36 MI Grants	9,164	14.00
37000	CSSA MI populations (16%)	7,715	.57
	Subtotal Comm. MI programs	$ 20,563	
1275	State Hospital MI	$ 51,430	$ 126.55
	Est. 87 Total MI	$ 71.993	
1000	MR Waiver	$ 7,670	$ 25.94
2900	MR DAC Services	$ 8,435	$ 79.70
5000	ICF/MR	$ 46,105	$ ~~252.06~~
900	SILS	$ 2,620	$ 79.73
250	MR Family Subsidy	$ 700	$ 76.71
18000	CSSA MR Populations (15.5%)	$ 7,470	$ 1.13
	Subtotal Comm. MR programs	$ 73,000	
1735	State Hospital MR	$ 44,925	$ 158.20
	Est. 87 Total MR	$ 117.925	
	Est. Statewide Totals F.Y. 87 =	$ 189,918	

Because of the continuing drop, particularly in MR patients in state hospitals the per diem cost is rising. The following table show this increase from 1983 thru 1987.

State Hospital per Plans 1983-1987

Category	1983	1984	1985	1986	Est. 1987	% of Inc. 83 to 87
MR	$109.50	123.25	135.85	147.35	158.20	44%
MI	$ 83.65	95.80	108.60	116.30	126.55	51%

Analysis of Alternatives

As indicated in the issue statement there are at least three alternative courses for the state to follow:

1. Continue present operation. No significant funding changes in either the state hospital or community programs.

2. Increase funding for state hospital programs, including establishing sattelite programs. At the same time, increase funding for community programs. In other words, continue to expand funding for both delivery systems.

3. Increase funding in community programs while decreasing funding for state hospitals, therely recognizing the inevitable decrease in state hospital populations and usage. Plan for phased closure of a substantial number of hospitals.

The following analyses will estimate the financial implications of each alternative.

ALTERNATIVE #1 - As is - No increases.

	1988	1989	Biennial Total	% of Total
RTC		$153.2	$ 310 .7	63%
Community MI	$157.	20.6	41 .2	8%
Community MR	5 20.6	73.0	146 .0	29%
Totals	73.0	$246.8	$ 497 .9	100%

Assumptions:

1. State hospital populati ons are proj ected as follo ws:

	Est. 1988	Est. 1989
MR	1540	1420
MI	1250	1200
Totals	2790	2620

2. State hospital budgets are based on DHS SAME level requests (see Exhibit I) but include MR staff decrease. No increase for MI staff.

3. Community program budgets are based on DHS SAME level requests (see Exhibit I) No increase for community MH programs.

ALTERNATIVE #2 - Increase funding for both RTC & Community programs.

RTC	$ 172.	169. 0	341.9	60%
Community MI	$ 23. 9	31. 2	54.3	10%
Community MR	$ 79.	88. 5	168.3	30%
Totals	$ 275.	288. 7	564.4	100%

Assumptions:

1. State hospital popul ations are project ed as follo ws:

	Est. 1988	Est. 1989
MR	1540	1420
MI	1250	1200
Totals	2790	2620

2. State hospital budgets are based on DHS CHANGE level requests (see Exhibit II).

3. Community program budgets are based on DHS CHANGE level requests (see Exhibit II).

Exhibit I

SAME Level Funding

RTC Estimated 88/89 Appropriation (SAME Level)

	Est. 1988	Est. Pop	Ann cost per patient	Est. 1989	Est. Pop	Ann cost per patient
Operating Budget	$ 177,347			$ 176,139		
Less 11% CD	x 89%			x 89%		
Net MI & MR	$ 157,840			156,760		
Less 349 MR Pos.Cut	(1,967)			(5,253)		
Capital Budget (86-87)	1,650			1,655		
Same level total	$ 157,523	2790	$ 56,460	$ 153,162	2620	$ 58,460
MI Community Programs 88/89 (SAME Level)						
Chronic MI Grants	$ 3,684	3200	$ 1,150	$ 3,684	3200	$ 1,150
Rule 12/36 Grants	9,164	1800	5,100	9,164	1800	5,100
CSSA MI Populations	7,715	37000	210	7,715	37000	210
MI Totals	$ 20,563			$ 20,563		
MR Community Programs 88/89 (SAME Level)						
MR Waiver	$ 7,670	1000	$ 7,670	$ 7,670	1000	$ 7,670
MR DAC Service	8,435	2900	2,900	8,435	2900	2,900
ICF/MR	46,105	5000	9,200	46,105	5000	9,200
SILS	2,620	900	2,910	2,620	900	2,910
MR Fam. Subs.	700	250	2,800	700	250	2,800
CSSA MR Serv.	7,470	18000	415	7,470		415
MR Totals	$ 73,000			$ 73,000		
TOTALS	$ 251,086			$ 246,725		

Exhibit II

CHANGE Level Funding

State Hospital Appropriation Estimates

	1988	1989
	$ 177.347	$ 176,139
	x 89%	x 89%
	$ 157,840	$ 156,760
SAME Level	-0-	864
Less 11% CD	(1,966)	(5,252)
Net MI/MR (SAME level)	737	1,952
	76	52
	2,635	1,995
	874	-0-
	900	950
	1,850	950
	595	175
CHANGE Levels		
MI Staff Enrichment		
MR Staff Reduction		
MR Staff Enrichment		
Hearing Impaired Svs.		
Repairs and Replacements		
Laundry Equipment-RTC's		
Service Workers Funding		
Info Systems in RTC's		
St. Op. Community Res. Svs.		
BRAINERO RHSC:		
Psycho-Geriatric Program	-0-	130
CAMBRIDGE RHSC:		
Dual Diagnosis Program	-0-	207
ST. PETER RTC:		
Hearing Impaired-MI Unit	270	360
Dual Diagnosis Svs.	-0-	209
SECURITY HOSPITAL:		
MSH Transition Lvg. Unit	172	451
Staff Increase	364	647
Capital Budget Req.	8,501	8,548
TOTAL RTC	$ 172,850	$ 169,000

MI Community Programs		
SAME Level	$ 20,563	$ 20,563
CHANGE Levels		
MH Initiatives	$ 2,094	$ 10,177
CSSA MI	485	485

	$ 23,142	$ 31,225
MR Community Programs		
SAME Level	$ 73,000	$ 73,000
CHANGE Levels		
MR Waiver (480/yr incr)	$ 4,363	9,770
MR DAC Services	503	1,094
ICF/MR Services	503	2,750
SILS Services	484	929
MR Fam Subs.	302	491
CSSA MR	470	470
Sub-Totals	$ 79,685	$ 88,504
TOTALS	$ 275,677	$ 288,729

Exhibit III

RTC Hospital budgets downsized from Same Level 12 1/2% (Equivalent of closing one of the eight hospitals). Note: Total savings could not be realized this bienmum because of closing costs estimated at $3 million per year.

	F.Y. 1988	F.Y. 1989
SAME Level	$177,347	$ 176,139
Less 11% CD	x 89%	x 89%
MI & MR	157,840	156,760
Less 249 MR Pos. Cut	(1, 967)	(5,253)
+ Capital (86/87)	1,650	
Net Same Level	$ 157,523	$ 153,162
Less 12 1/2% down sizing	x 87 1/2%	x 87 1/2%
TOTAL after downsizing	$ 137,832	$ 134,017

Estimated Annual RTC Cost per Bed - Comparison by Alternative

Alternative #1	$ 56,460	$ 58,460
Alternative #2	$ 61,995	$ 64,500
Alternative #3	$ 49,400	$ 51,150

EB/JS/SC/443I

Alternative #3 - Downsize RTC & Invest in Community programs.

RTC	$ 137.8	134.0	271.8	55%
Community MI	$ 23.1	31.2	54.3	12%
Community MR	$ 79.7	88.5	168.2	33%
Totals	$ 240.6	253.7	494.3	100%

Assumptions:

1. State hospital populations are projected as follows:

	Est. 1988	Est. 1989
MI	1250	1200
MR	1540	1420
Totals	2790	2620

2. State hospital budgets are based upon DHS SAME level requests reduced by 12 1/2 % (equivalent of downsizing by 1 RTC) (see Exhibit III).

3. Community program budgets are based on DHS CHANGE level requests (see Exhibit II).